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# Best Practices at Scale in the Home, Community and Facilities

## An Action Plan for Maternal, Neonatal, Child Health and Nutrition
### October 2011 to September 2016

***March 2011 (for external review)***

# USAID/Philippines
# BEST Action Plan
# October 2011 to September 2016

## 1. Country Context

The Philippines is an archipelago comprising over 7,000 islands (1,200 of them inhabited) divided into 17 Regions, 80 provinces, 1,600 municipalities (including 136 cities) and approximately 43,000 villages or barangays. The population is almost 100 million, of which 12 million live in Metro Manila. Economic growth rates have not been sustained at a level sufficient to raise real incomes and reduce poverty. It is estimated that 40% of the Philippines population live on less than $2 a day. The poorest areas of the country are concentrated in conflict-affected areas of Mindanao, where up to 70% of the population lives in poverty.

The Philippines has a dual health system consisting of the public and the private sector, with approximately 50% of the population seeking care in the private and informal sectors. The public health system is largely administered by the Department of Health and its attached agencies including Philippine Health Insurance Corporation (which implements the National Health Insurance Program) and local government units (LGUs). The DOH mandate is to formulate policies and national plans, technical standards and regulatory guidelines for health. It has a national office, 17 regional offices, retained hospitals, and relatively small teams of DOH representatives at the provincial level. With the devolution of health services in 1991 provision of direct health services is the mandate of the LGUs rather than the national government. Provinces manage provincial and district hospitals while municipalities/chartered cities manage rural health units (RHU), barangay health stations (BHS), and municipal/city hospitals. The private sector ranges from private hospitals, clinics, and pharmacies, to informal and traditional providers.

Family health (FH) indicators in the Philippines are very mixed, with some important areas of weakness; generally the country's pace of improvement has been below that of its immediate neighbors since the 1990s. Maternal and child mortality have been slowly declining in the Philippines, but a number of changes are still needed to bring down the maternal mortality ratio (MMR) and under-5 mortality in order to meet the Millennium Development Goals (MDG). The MMR is being debated and estimates range from 84-162/100,000 live births -- still significantly higher than the MDG of 52 by 2015. Disparity across the regions can be observed with the Autonomous Region in Muslim Mindanao (ARMM) having one of the highest maternal mortality rates. Nationally, the DHS 2008 showed that only 44% of deliveries were facility-based, although 62% were assisted by a skilled health provider. The two leading causes of maternal deaths are severe eclampsia and post-partum hemorrhage. Delayed access of pregnant women to health care is due to delay in consultation, delay in reaching a health facility, and delay in receiving appropriate care. Neonatal mortality is relatively low compared to some neighboring countries (16 per 1,000 births in 2008), but has not improved markedly over the last decade (18 per 1,000 births in 1998). Mortality rates for infants (25) and children under-5 (34) show a similar picture: slow improvement, but in most instances the Philippines has not kept up with neighboring countries. Neonatal deaths account for 64% of infant deaths and essential newborn care is not widely practiced. The leading causes of neonatal deaths are due to pre-

maturity, sepsis/pneumonia and asphyxia accounting for 75% of neonate deaths while pneumonia and diarrhea accounts for 57% of under-5 children's deaths.

Full immunization coverage (FIC) is at 80% (or 70% within 12 months). Adherence to breastfeeding, and especially exclusive breastfeeding, is weak: only 23% of children aged up to 6 months had been exclusively breastfed during the 2008 DHS survey. Among children aged up to 2 years, only 55% are fed in accordance with all three infant and young child feeding protocols. This contributes to significant levels of stunting in children. In 2008, the prevalence of underweight children 0-5 years old was 20%. Child micronutrient intake is good with respect to Vitamin A but less adequate with respect to iron; neonatal, under-5 and women's anemia rates remain high.

Total fertility has edged down from 6.0 in the 1970s to 3.3 today and the mean ideal number of children across all women is at 2.8. Among the poorest women, the fertility rate is still high at 5.2. Unmet need remains significant – 9% for spacing and 13% for limiting in 2008, both higher than in 2003. USAID no longer donates contraceptives and UNFPA is now the only donor who does. The private sector's share of sourcing for FP services rose dramatically between 2003 and 2008 (from 29% to 51%). Since CPR barely moved over the same period, this suggests that the private sector has successfully moved into the space vacated by donors, with no negative (or positive) impact on overall use. Public sector contraceptive procurement is now the responsibility of the LGUs, not the national government. LGUs' procurement approaches for contraceptive commodities remain extremely varied. Contraceptive use among the lowest wealth quintile of women remains very low (26% modern methods in 2008).

## 2. FP/MCH/N Goals and Objectives and USAID/Philippines Health Strategy

Under its new health strategy (October 2011 to September 2016) USAID/Philippines aims to improve the health of Filipino families by helping to expand access to integrated FP/MCH/N services at the community and facility level, and by strengthening the capacity of the local government units (LGUs) and the private sector to plan, carry out, and monitor those services.

The Development Objective (DO) for the new strategy is "**Family Health Sustainably Improved."** Three Intermediate Results (IRs) focus on:

- IR 1 – Improve the supply of services, including the availability and quality of public sector services and selective expansion of the private sector as a primary care supplier.
- IR 2 - Strengthen demand for primary care services through encouraging adoption of appropriate healthy behaviors within families. This includes better interpersonal communication and counseling, expanded use of mass media, and a re-energized approach to community mobilization and expanded advocacy efforts.
- IR3 – Remove policy and systems barriers to improve supply of and demand for services.

The new strategy will provide support to the Department of Health and the private sector to help the Philippines achieve its Millennium Development Goals (MDGs) for health. It aims to decrease the morbidity and mortality of mothers, newborns and children and reduce unmet need for family planning with a focus on the most vulnerable families.

USAID, in collaboration with government and other development partners, expects to contribute to the achievement of the following impact indicators for the 2011-2016 BEST period[1]:

- Increase modern contraceptive prevalence rate from 34% to 42%
- Decrease under five mortality rate from 34 per 1,000 live births to 27
- Decrease maternal mortality ratio from 162 per 100,000 live births to 60
- Reduce prevalence of underweight children 0-5 years old from 20.6% to 15%

**3. Relationship of USAID/Philippines's proposed FP/MCH/N investments to national priorities and plans**

USAID/Philippines' investments in FP/MCH/N closely align with the priorities of the newly elected Aquino Administration and the Department of Health. The Aquino Health Agenda (AHA) is embodied in the recently launched Universal Health Care (UHC) Initiative. It intends to scale-up health reform implementation while making sure that the poor are not left behind. The UHC has three strategic thrusts, namely:

1) Improving financial risk protection by reforming the National Health Insurance Program (NHIP): Improving financial risk protection aims to achieve universal insurance coverage for all by 2013. This will entail the enrollment of around 5 million of the poorest families, the provision of membership services to empower members to avail of benefits, the provision of outpatient care services that are co-financed by capitation (a fixed payment from PhilHealth per person served), and the provision of critical inpatient services with no copayment in government hospitals.

2) Enhancing health facilities to improve access to quality health care: Health facilities enhancement aims to improve the capacity of selected RHUs and hospitals to provide services and improve sustainability.

3) Attaining the health-related Millennium Development Goals (MDGs). This will involve intensifying efforts to implement public health programs, especially those addressing maternal and neonatal mortality - the MDG most at risk of being missed in 2015. The AHA-UHC recognizes that attaining desired health outcomes involves the proper utilization of critical services by clients from both public and private providers.

National goals, objectives and targets are currently being established in the new National Objectives for Health (NOH). The overarching goal of the current NOH 2005 to 2010 is to "ensure accessibility and quality of health care to improve the quality of life of all Filipinos, especially the poor." The primary objectives of the health sector are:

- Better health outcomes
- More responsive health system
- More equitable health care financing

[1] These targets are derived from national targets which are listed in the attached tables.

Several important MNCH/N policies have been disseminated recently that demonstrate a strong commitment to improving maternal, neonatal and child health; these are discussed under Successes and Opportunities below.

## 4. Barriers to achieving FP/MCH/N goals and successes upon which to build

USAID/Philippines has identified the following challenges to improvements in FP/MCH/N:

Limited Capacity in Health Service Delivery at LGU level - Devolution of responsibility for health care to Local Government Units (LGUs) in 1991 continues to provide an all-consuming policy and service delivery challenge. Financing for health care is dependent on 1,700 individual LGUs that have to make decisions on how much of their local Internal Revenue Allotments to devote to health. Additionally, PhilHealth coverage remains sparse. The 2008 DHS showed that only around 38% of respondents were enrolled in Philhealth. Coverage ranged from 21% among persons in households in the lowest quintile to 65% among those in the highest wealth quintile. This results in lack of health infrastructure, lack of essential equipment, and scarcity of trained personnel, particularly in remote areas.

Weak Behavior Change Programs - The 2008 DHS demonstrates that there are multiple, continuing gaps in knowledge and behavior across the family health spectrum. Interpersonal communication and counseling (IPC/C) skills of health providers and community health workers are limited and there are few trained communication professionals at the municipal level. For example, FP is not discussed or offered as a routine part of good health care; 82% of non-users have never been contacted about FP. The system of community health workers that was very strong in the 80s still exists, but it needs rejuvenation, and volunteers need updated information.

Conflict in the Autonomous Region of Muslim Mindanao (ARMM) - The health indicators in ARMM have historically been the weakest in the Philippines, standing today at roughly 30-50% of national accomplishments. For example, national FIC coverage is 80% compared with only 31% in ARMM. ARMM is hampered by many barriers including armed conflict and tribal warfare, large numbers of internally displaced populations, extremely limited access to health services, particularly in the island provinces, and weak health systems and governance.

Inequities in Access to Healthcare – Large income and regional disparities still exist in the Philippines, despite economic growth. The poorest have worse health outcomes (and higher unmet need for family planning), low financial risk protection, higher out-of-pocket payments, and less access to quality health services.

**Successes and Opportunities include:**

Positive Political Commitment and Momentum - The Aquino Administration has clearly voiced support for meeting the MDG targets, addressing inequalities in accessing health services, supporting free and informed choice regarding family planning. President Aquino has also committed to providing conditional cash transfers to the five million poorest households in the

Philippines, linking them with essential health services such as immunizations and pre-natal care, and enrolling them in the National Health Insurance Program.

New protocol and commitment to scale-up Essential Newborn Care - The Department of Health has launched a new policy and protocol for Essential Newborn Care that is evidence-based and has shown a 50% reduction in newborn mortality in pilot sites. The new protocol is entitled "The First Embrace" and comprises a complete package of policies and training materials that can be rapidly scaled-up. The protocol includes newborn drying and warmth, skin-to-skin contact, appropriate cord care, and immediate and exclusive breastfeeding.

Maternal, Newborn Child Health and Nutrition Strategy (MNCHN) - In 2008, recognizing the slow decline in both MMR and NMR, and hoping to meet the MDG 4 and 5 targets by 2015, the DOH declared that universal access to a standard maternal and newborn health service package was a basic right of all women of reproductive age. DOH updated the standards of care to meet WHO global standards such as active management of the third stage of labor (AMTSL) to prevent postpartum hemorrhage. The new policy supports an integrated package of services including maternal, newborn, child health and nutrition (MNCHN). Further, it recognizes FP as an essential and integrated component of the strategy.

Strong support for a Child Health Strategy – The Garantisadong Pambata (Guaranteed Childhood or GP) is a multi-sectoral child health information and services strategy for 0-14 year olds (but with a focus on under 5's) recently launched by the Department of Health that serves as a platform for improving health-seeking behavior and empowering families to make healthy choices at the household level.

## 5. Key interventions

Based on several program assessments, focus group discussions with stakeholders such as DOH and LGU staff, and analysis conducted by a joint USAID/Washington and USAID/Philippines strategy development team in October 2010 (using the BEST interventions as a reference), USAID/P proposes the following as the most appropriate and feasible set of high impact FP/MCH/N interventions for the Philippines:

### Family Planning

The pace of increase in modern contraceptive use in the Philippines has been very slow, rising from 21.6% in 1988 to 34% in 2008, less than 13 percentage points in a 20-year period. Myths and misconceptions about the dangers of family planning abound. Two of the major reasons for non-use of contraception are health concerns (21% of non-users in the 2008 DHS) and fear of side effects (14 percent of non-users).

With a new administration and supportive President, as well as growing public acceptance of family planning, there appears to be a real and unique opportunity to develop and strengthen a true family planning norm in the Philippines. The Mission will implement the following high-impact interventions to position family planning as an integral part of good health care:

- Strengthen communications, outreach and services at all levels with a special focus on dispelling myths and misconceptions at the community level;
- Scale up interpersonal counseling and communication (IPCC) training with all providers, not just "family planning" staff;
- Ensure women are screened proactively for family planning needs at all interactions with the health care system;
- Scale up integration of family planning and MCH services to target women during prenatal care, post-partum, and during well-child visits.

Before the 1991 devolution of health services to the LGUs, the responsibility for training health care providers rested with the Department of Health or, in the case of family planning, with the Population Commission. Today, the DOH still has nominal responsibility for training, but in reality there are few regional DOH staff and little DOH funding devoted to keeping provider skills up to date. New midwives come out of school with academic training, but little hands-on training. Older midwives have not had any refresher training in years. Unmet need for family planning limiting methods is particularly high, at 13% of women of reproductive age. In part this is due to the shortage of providers of long-term and permanent methods, particularly tubal ligations. When tubal ligations are offered, particularly in ambulatory facilities, the available slots are filled immediately. Key interventions to increase the supply of high-quality family planning services will include the following:

- Support in-service training for new midwives on basic FP; provide training for public and private providers, especially in long-acting and permanent methods;
- Introduce community-based distribution of oral contraceptives and injectables; train public and private providers on contraceptive methods available immediately post-partum at the delivery site;
- Train managers on supportive supervision techniques to reinforce on-the-job learning of providers and to monitor quality;
- Increase the number of private health providers offering LAPMs by training more providers, especially in strategic locations;
- Increase availability of family planning services for working men and women and through private midwife clinics.

Contraceptive security is a long-standing issue, with the LGUs, rather than the national government, bearing the responsibility for providing contraceptives to the poor. Great strides have already been made in working with mayors and governors to provide contraceptives for the poor, and in working with the private sector to introduce moderately-priced contraceptives in the Philippines. Key interventions to assure contraceptive security for larger numbers of family planning users will include the following:

- Strengthen the ability of Local Government Units to better plan, forecast, budget and procure contraceptive commodities;
- Assure contraceptive commodity security through increased budget contributions from the government;
- Support efforts to ensure that a wider range of affordable products is available in the private sector; and

- Partner with the private sector to make injectables more widely available where appropriate, such as in pharmacies.

**Maternal and Newborn Care**

The value, vision and adoption of global standards by the DOH in maternal and newborn care are excellent. However, there are significant gaps and challenges in the implementation of the standards that need to be addressed. The lack of updated skills among midwives is one of the greatest impediments to improved maternal and neonatal care. In many instances, proven low-cost practices to improve maternal and newborn care are not routinely used. USAID/Philippines has only a small budget for maternal/newborn care, so it will focus on the following high-impact interventions:

***Enhanced antenatal care (ANC):*** DHS data shows that antenatal care visits are high with the majority of women attending at least 3 of the 4 recommended visits. USAID will leverage these interactions with women by initiating group ANC sessions with a focus on increasing uptake of iron folate, improved intake of protein to address anemia, birth preparedness plans, and deworming. The group counseling model will be extended after delivery to increase uptake of exclusive breastfeeding (EBF) and appropriate complementary foods for children aged 6 months to 2 years, and other healthy infant and child care behaviors.

***Improved Birth Attendant Skills:*** Build the capability of midwives to implement proven, high impact interventions (e.g AMTSL and ENC); strengthen the DOH MNCHN delivery network; support professional associations of obstetricians and midwives to improve skills; and facilitate policy changes needed for midwives to implement best practices in remote settings such as administration of life-saving drugs (oxytocin and magnesium sulfate). We will support expansion of women's /community health teams to identify and refer pregnant women for antenatal and facility based delivery, and promote mechanisms for transport and communication. USAID will also support the introduction of uniject for the administration of oxytocin. ENC training and integrated training under the FP component will also contribute to strengthening the capacity of midwives in the Philippines.

***Expand the use of essential newborn care:*** In 2008, the Philippines lost 34 newborns to sepsis in a large urban hospital. This prompted research, in collaboration with WHO, that identified causes and made recommendations for significant policy changes to improve the situation. This led to a DOH ENC protocol, strong DOH ownership of this protocol, and the development of an initiative to improve newborn health and survival. Building on the simple new ENC protocol, the USAID strategy will use classroom, internet, and on-the-job training to reach large numbers of providers in birthing facilities with ENC; disseminate information on ENC and evaluate the uptake and use of ENC by midwives and other health providers; share ENC information in communities to improve awareness and promote healthy behaviors in the care of the newborn by mothers and families. Once ENC has been widely disseminated, USAID/Philippines will assist the DOH to expand the training to address neonatal resuscitation.

**Child Health**

Child mortality in the Philippines has dropped more sharply than maternal or neonatal mortality, declining from 40 to 34 deaths per 1,000 between 2003 and 2008, with the main causes of mortality (based on CHERG estimates) being pneumonia (30%), diarrhea (27%), and malaria (13%). Given the improvement in child mortality, USAID/P will use its limited MCH funds primarily for maternal and neonatal activities. Child health activities will focus on improving mothers' health-seeking behaviors for under-5s, particularly through the community/women's health teams.

High-impact activities to improve health-seeking behavior, which will support the Government's GP strategy, will include support to replicate the community/women's health team (C/WHT) training and scale up, where appropriate. Child health messages will be developed to cover vaccine preventable diseases, diarrhea and hygiene. The C/WHTs will find and target services to the women and families that do not seek services and have the poorest health indicators. We will also continue to support the roll-out of DOH policy on treatment of ORS with zinc.

***Water Supply and Sanitation:*** USAID/P Office of Health has not worked directly in water and sanitation to date. Working with current activities of the USAID/P Office of Environment which works on water and sanitation issues with the DOH, USAID/P will target underserved LGUs to upgrade water supply and sanitation systems, and increase access to potable water in underserved areas through a grant-making mechanism to which the DOH has allocated approximately $30 million. Assistance will also be provided to LGUs to develop and disseminate simple behavior change communication materials for use by CHTs with the appropriate messages on using clean water, proper hand-washing and hygiene including improved sanitation practices to prevent diarrhea and under-5 deaths. Since water and sanitation is a new area of assistance for USAID/Philippines our interventions and targets will be refined and articulated by the last quarter of FY2011.

**Nutrition**

With Philippine Government policies already in place (Infants and Young Child Feeding Administrative Order, MNCHN Administrative Order, Micronutrient Supplementation Administrative Order, Early Newborn Care Administrative Order), USAID will step up support to nutrition activities beyond Vitamin A supplementation, which USAID has supported for over 15 years. In order to ensure that limited resources result to improved nutrition outcomes, formative research at the community level on exclusive breastfeeding, complementary feeding, stunting and malnutrition that will be undertaken to identify appropriate and effective interventions. Assistance will be given to local health providers to develop and disseminate simple materials for use by community and women's health teams with the appropriate nutrition messages as well as messages on hand washing and hygiene to prevent diarrhea that can lead to malnutrition. In addition, USAID will continue providing technical assistance to LGUs in strengthening their ability to plan, forecast and budget for community nutrition programs. We will work with the private sector for the introduction and social marketing of micronutrient powders fortification or point of use fortification (e.g. Sprinkles) might be initiated, particularly in LGUs that already have complementary feeding programs. In-as-much as broader nutrition coverage is a new area of assistance for USAID/Philippines, our interventions and targets will be refined and articulated by the last quarter of FY2011. Currently we are conducting a

sustainability assessment and from preliminary information, it is likely that the DOH can continue to maintain high levels of coverage without USAID assistance. Therefore, we have not included this in our list of BEST interventions.

## 6. FP/MCH/N outcome targets – 2010 Baseline and 2016 Targets

Listed below are the core outcome indicators for the BEST program which are also reflected in the attached tables. As part of our new health strategy the Mission will develop a full performance monitoring plan that will be complete by September 2011.

| | Indicator | Baseline (2010) | Target (2016) | Type |
|---|---|---|---|---|
| **FAMILY PLANNING** | | | | |
| **1** | Number of counseling visits for FP/RH as a result of USG assistance | 615,524 | 1.2 million | OP |
| **2** | Number of USG-assisted service delivery points providing FP counseling or services | 280 | 840 | OP |
| **3** | Number of people trained in FP/RH with USG funds | 5,445 | 7,500 | OP |
| **4** | Unmet need for family planning | 22% (2008) | 14% | DHS |
| **5** | Unmet need for limiting methods | 13% (2008) | 7% | DHS |
| **6** | Percentage of women who reported discussing FP information with health care providers | 12% (2008) | 50% | DHS |
| **7** | Percentage of RHUs that offer FP counseling for post-partum women | 6% | 75% | OP/custom |
| **8** | Percentage of women citing fear of side effects and health concerns as reasons for non-use of contraception | 35% (2008) | 25% | DHS |
| **9** | Amount of in-country public and private financial resources leveraged by USG programs for FP/RH | USD 11.1 million | USD 13.5 million | OP |
| **10** | Number of LGUs implementing their Contraceptive Self Reliance (CSR) plans | 72 | 630 | OP/custom |
| **11** | Annual sales of USG supported oral contraceptives (in cycles) | 9.8 million | 10.9 million | OP/custom |
| **12** | Annual sales of injectables in private sector (in vials) | 259,0000 | 367,0000 | OP/custom |
| **MATERNAL AND CHILD HEALTH** | | | | |
| 1 | Percentage of deliveries with skilled birth attendants in USG-assisted program | 62% (2008) | 70% | DHS |
| 2 | Percentage of facility-based deliveries | 44% (2008) | 60% | DHS |
| 3 | Number of Maternity Care Package-accredited health facilities | 259 | 750 | OP/custom |

| | | | | |
|---|---|---|---|---|
| 4 | Number of people trained in maternal/newborn health through USG-supported programs (specifically including AMTSL and ENC) | 504 | 6,500 | OP |
| 5 | Percent of children under five years old with diarrhea treated with Oral Rehydration Therapy | 59% (2008) | 70% | OP |
| **NUTRITION** | | | | |
| 1 | Percent of infants exclusively breastfed in the first six months | 23% | 30% | DHS |
| 2 | Number of people trained in child health and nutrition through USG-supported program | 4,579 | 7,500 | OP |

## 7. Key health systems improvements required for near term and longer term scale-up

Given the barriers mentioned above, the following are the main thrusts of health systems strengthening under the BEST Action Plan. These build upon the work already done by USAID/P but move beyond the provincial level to ensure improved health outcomes at the clinic and community level.

Strengthen LGU capacity - Continue to improve the capacity for health planning, management and financing at the LGU level. Help the DOH and LGUs to institutionalize the central, performance-based grants that represent the current core of national financing for LGU service delivery. Continue support to LGUs on investment planning for health and to develop models for fee and other revenue retention at RHUs and local hospitals to improve their independence. Assist PhilHealth to make its primary care provision more comprehensive and move from fee-for-service to case-based provider payments. Assist LGUs to increase the proportion of MHCs/RHUs that are PhilHealth-accredited.

Health Data Quality, Accuracy and Timeliness - Improve the quality of data at the provincial and municipal level and ensure that data is used for local policy-making, program monitoring, planning and quality improvements.

## 8. Delivery Approach

Building on past efforts, The BEST Action Plan will have nation-wide impact on key MCH/FP/N indicators by supporting activities at four levels:

- National: Operationalize existing plans and policies, expanding health promotion and advocacy, capacity building, and provide support for key national programs such as National Center for Disease Prevention and Control (primarily FP and MCH), the National Center for Health Promotion, and PhilHealth.
- Provincial and municipal: Provide capacity building for implementing high impact services in approximately 35 out of the 80 provinces, including all five provinces in ARMM, and selected cities. This represents approximately 40 percent of the population.

Interventions at the provincial level include planning, forecasting, budgeting and implementing key MCH/FP services. USAID/P will also support organization of service delivery networks in the province to ensure proper flow of referral across health facilities, both public and private.

- Facility: Supporting approximately 840 RHUs to provide improved MCH/FP/N services through training, supportive supervision, and key HSS interventions.
- Community - Focus will be on scaling up community level information and referral through barangay health workers, community health teams, and the GP. Current USAID/P-supported projects have worked with community health action teams in ARMM, with barangay health workers (BHW) throughout the country and with Community/Women's Health Teams. USAID developed, and the Department of Health recently adopted, the Family Health Book, a tool to be used by community health workers in improving MNCHN practices. Under BEST, USAID will focus on assisting the DOH to scale up the women's health teams, especially in under-served areas.

Cross-cutting delivery approaches include the following:

- Leveraging LGU resources: Building on strong relations already developed, USAID will continue to leverage LGU resources to scale up training and community mobilization activities. The current program has been able to leverage significant local resources, both in kind and in cash.
- Health communication – Under our current strategy, USAID has developed a set of updated communication materials, job aids, and BCC approaches that will be scaled up. USAID will reinvigorate IPCC, community mobilization and advocacy, through expanded IPCC training, exploring a wider role for Community/Women's Health Teams in the full spectrum of family health (FH), working with NGOs to organize community mobilization, making wider use of influentials to address FH topics, and creating a more unified management structure for demand generation at the facility and community levels. We will continue capacity-building at the national level and regional level, with a focus on mass media, a national BCC strategy and materials production.
- Policy – Policy work will focus on removing barriers to scaling up high impact services, greater involvement of the private sector, and securing sustainable financing for health. The policy agenda will inevitably evolve over the five years of the program. Issues that are apparent today and need tackling include regulation of the private sector, amendment of the PhilHealth law, and updating the midwifery law to give midwives greater legal protection to practice high impact interventions.
- Private sector – USAID is currently working with the private sector on FP/MCH programs, support to private sector midwives, and expanding the market for low-cost contraceptives. Under BEST, engaging the private sector will focus on provision of contraceptive choice through introduction of new products, supply of affordable contraceptives for the near-poor, expanding access to FP/MCH information and services among working men and women, encouraging private midwife participation in provision of high quality safe delivery and new attention to commercial pharmacies as a source of accurate information and counseling for existing and prospective new FH clients.

- Special considerations for operating in ARMM – There are special environmental and cultural factors to be addressed when implementing in ARMM. Behavior change and other implementation strategies will need to be tailored to meet the needs of isolated communities and island barangays. More focus will be given to support routine outreach services to expand access to services, focus on basic service delivery, and to exploring the possibility of allowing community volunteers to provide a limited set of health services. A recent assessment of the health situation in ARMM will help USAID/P facilitate progress in this particularly under-served area.
- Equity –The Department of Health Universal Health Care Initiative focuses on ensuring that the very poor and the disadvantaged are given access to health care, and targets families enrolled in the conditional cash transfer program. USAID will assist by providing mechanisms to rapidly scale up high-impact health interventions in conditional cash transfer (CCT) areas. We will also help design service delivery models for Geographically Isolated and Disadvantaged Areas (GIDAs) that focus on service delivery by non-health professionals and regular outreach services.

**9. Existing areas of integration in the country's MCH/FP/N programming**

The current USAID/P five-year health strategy focuses on integration, particularly in local-level health systems strengthening, and the program includes several strong integrated components:

Health System Strengthening - USAID/P has been a pioneer in integrated health system strengthening at the local government unit (LGU) level (provinces, cities and municipalities) to support a decentralized health system where LGUs are entirely responsible for delivery of primary health care services. USAID supports integrated planning and budgeting through five-year Investment Plans for Health and Annual Operation Plans (AOPs). Other key HSS activities include integrated supervision, commodity planning and budgeting, support to the National Health Insurance Program (PhilHealth), and policy support for integrated programming. Interface with CCT will be developed when providing technical assistance, training and other support.

Service Delivery – USAID supports the DOH's integrated Maternal, Neonatal, Child Health and Nutrition strategy (of which FP is a strong component) which promotes "integrated MNCHN services including pre-pregnancy services, antenatal care, care during delivery and postpartum and postnatal care." In addition, USAID supports integrated training of health providers in MNCHN skills, including FP, AMSTL and ENC.

Demand Creation and Community-Based Approaches – USAID/P supports integrated health communication through comprehensive behavior change strategies at the national level and more focused support in 30 target provinces. Interventions include training local media, developing patient education materials, interpersonal communication, job aids, health events, community mobilization, and peer education through community-based integrated women's health teams. Messages include FP, MCH, N, TB and HIV/AIDS.

Private Sector – USAID supports integrated MCH/FP/TB in the private sector through improved access to services and information, support for private sector midwifery clinics, and work with local pharmaceutical companies to expand access to low-cost FP commodities and other key MCH commodities such as ORS and zinc.

**10. Most important opportunities for additional "smart" integration**

Service Delivery –Under the new strategy, service providers will be encouraged to think about and act on clients' needs holistically, not just in terms of a single health element. Specifically, FP will be integrated into: the provision of maternal health (ANC, post-partum, and postnatal visits); regular national child health campaigns (*Garantisadong Pambata* [GP]) which include exclusive breastfeeding, appropriate complementary feeding practices, immunization, Vitamin A, BCC and other child health interventions; the provision of STI check-ups for registered commercial sex workers; and HIV counseling, testing, and treatment service provision.

Demand Creation and Community-based Approaches – In this area, three key integrated approaches will be scaled up: 1) training and support of existing and new Community/Women's Health Teams in promoting facility-based delivery and family planning, 2) integrated interpersonal communication training for facility staff (primarily midwives), and 3) support to the DOH Child Health Week (GP), a platform for the integrated delivery of maternal and child health care services, including family planning.

Medical Products, Vaccines, and Technologies – USAID/P currently provides TA to the DOH and LGUs to help them achieve not only contraceptive self-reliance but also other commodities such as vitamin A, ORS, TB drugs, and zinc (CSR+). USAID will expand the assistance to at least 600 municipalities. USAID/P has been doing CSR+ since 2004.

Coastal Resource Management and Health – Coastal subsistence fishing communities are among the most densely populated, the poorest, and suffer from the highest rates of malnutrition in the Philippines. The USAID/P Offices of Health and Environment will continue to increase CPR and reduce unmet need for family planning in these key areas of marine biodiversity through integrated coastal resource management/family planning programming.

**11. Opportunities for collaboration/leverage with other USG and development partner health sector investments and with other sectors**

Family Planning - USAID will work closely with UNFPA to maximize impact in FP. UNFPA provides donated contraceptive commodities and technical assistance in several provinces, and undertakes qualitative research on FP issues. Areas of collaboration include FP policy advocacy at the national level, sharing data on training activities, and coordination to assure consistent communication messages and materials. USAID will provide assistance to LGUs on identifying and targeting the poor for UNFPA donated commodities. USAID will use the results of UNFPA studies on communications interventions to inform our programming. USAID is also working with UNFPA in selected areas to increase access to voluntary sterilization services: USAID organizes the surgical teams and UNFPA provides the supplies.

Maternal, Neonatal and Child Health and Nutrition (MNCHN) - USAID and JICA will continue to collaborate in two provinces where JICA is focusing on upgrading birthing facilities with equipment and training in MCH, and USAID is integrating FP into this training. In addition, USAID will coordinate with the AusAID funded joint UN-DOH program on maternal and newborn death reduction, as well as with WHO and UNICEF on studies and support for the development of the essential newborn care protocols, including a "First Embrace" campaign and assistance to the DOH to scale up the program. USAID will also reach out colleagues at the U.S Centers for Disease Control (CDC) who provide regional TA to the WHO.

Agriculture and Health – The Office of Health (OH) will seek to strengthen linkages between health programs and health/nutrition/agriculture activities including feeding programs and linkages to bio-fortified products. The Office of Health will reach out to internal partners such as the Office of Economic Growth, the national Department of Agriculture and the Foreign Agriculture Service of the USDA.

Water Supply and Sanitation and Health – USAID/P/Office of Health (OH) will proactively coordinate internally with the Office of Environment and Energy and externally with the Department of Health to assist LGUs to upgrade water supply systems, improve water quality and increase access to water in geographically isolated and depressed areas. OH together with OEE will provide technical assistance to LGUs and help introduce community based, low-tech inputs that can improve water access and quality and improved sanitation.

Military - USAID coordinates closely with the U.S. Department of Defense (DOD) in the Philippines. USAID houses a full-time DOD liaison from the Mindanao Joint Strategic Operations Task Force (JSOTF). Post Manila employs a whole-of-government approach in the most insecure provinces with defense, development and diplomacy working together to increase access to government services in conflict-affected areas. In addition, we coordinate with DOD on their twice yearly civil-military exercises throughout the country which include medical missions. DOD coordinates with USAID on site selection and USAID provides medical profiles of the area, links to local health officials, and health education materials.

## 12. Resource plan

USAID/Philippines used past budget trends and the actual FY 2010 budget as a basis for projecting funding over the five year BEST Action Plan period. It is projected that we will receive approximately $ 21 Million per year for combined FP/MCH/Nutrition activities.

## 13. Monitoring, evaluation, research, and innovation

Ongoing monitoring and evaluation includes the annual Performance Plan and Report process at the Mission level and monitoring and evaluation activities within individual projects, including midterm and final evaluations. The Mission also conducts mid-term and final evaluations of the entire health portfolio during each strategy period. The latest Demographic and Health Survey (DHS) was in 2008 and will provide baseline information for many of the indicators proposed in this strategy. The next DHS is scheduled for 2013. In addition, USAID will conduct a modified DHS (using 'rider" questions in a national survey conducted by NSO) every two years (2011 is

already planned). Other data sources include the national Field Health Service Information System (FHSIS), and other specialized surveys. In addition, USAID/P will work with GH/PRH in the systematic documentation of scale up processes and results. An organized documentation of best practice scale up will be an important resource for replication in-country and for sharing with other Missions, in support of GHI's research utilization and learning agenda.

Operations research (OR): OR will be carried out as appropriate to inform programmatic decision making. In addition, formative research on breastfeeding, weaning, and complementary feeding practices will be used to develop appropriate communications messages for nutrition interventions, and research on select contraceptive technologies such as injectables and implants will be used to determine the best methods to scale-up as well as appropriate messaging.

Innovations: Cell phones cover over 90% of the country, including many difficult-to-access, remote provinces and islands. USAID/P will explore the use of cell-phone based technologies to improve health communications, care-seeking behavior, and referral systems.

**14. What is different? What hard choices were made?**

The USAID health strategy and BEST Action plan build on the successes and foundation of USAID's previous strategy but diverges from its predecessor in the following ways:

- Due to a limited budget for maternal and child health, USAID/P will be unable to implement a full package of child health interventions, but will instead focus on high-impact interventions for neonatal survival, which is in line with the epidemiological context and GRP priorities. By promoting an integrated package of interventions, including MCH and FP, USAID/P will also maximize the impact of the limited MCH funding that is available. Additionally, the increased focus on family planning will help to bring down maternal mortality and morbidity by decreasing the number of high-risk births.
- An enhanced focus on FP, including integrating FP with other services, as well as creating a new social norm around use of contraception. The Mission will work closely with the new GRP/DOH administration, which is the first to support a comprehensive package of family planning services in over a decade.
- Stronger focus on health outcomes and emphasis on service delivery from both the supply and demand sides. Policy and health systems strengthening will still be important but will be approached as inputs needed to achieve the desired health outcomes.
- A greater focus on the municipal and community levels for both service delivery and demand generation, with replication of successful interventions in a greater proportion of municipalities and communities in USG areas.
- Stronger emphasis on financing and equity – The new strategy aims to improve the reliability of financing for both the suppliers and consumers of family health, through sustaining central DOH grants to LGUs, allocating LGUs' Internal Revenue Allotments more reliably to health, and improving PhilHealth coverage .
- More engagement of the private sector both in providing services and creating demand for health

- Integration with water and sanitation sectors to highlight the importance of these two interventions to address health issues that contribute to morbidity and mortality.
- Focus on coastal resources to respond to the health needs of the disadvantaged sector and their families as well as contributing to the natural and economic resources of the community.
- Reduce the production of new tools. Scale up the use of tools, such as IPCC training modules, developed during the previous strategy.

## BEST Action Plan Results Framework Table: Overall

| | Staff |
|---|---|
| **FTE(s) Nut** | .5 |
| **FTE(s) FP** | 4 |
| **FTE(s) MCH** | 2 |

| **USAID/ PHILIPPINES BEST Program** | |
|---|---|
| **Goals/Objective** | **Family Health Sustainably Improved** |
| **Cross-Cutting Information** | |
| **Key Areas of Integration** | ***Current Areas of Integration***<br><br>• Communication – USAID/P supports integrated health communication through comprehensive behavior change strategies at the national level and more focused support in over 30 target provinces and cities. Interventions include local media, patient education materials, interpersonal communication, job aids, health events, community mobilization and peer education. Messages include FP, MCH, N, TB, HIV/AIDS. Three key integrated approaches that will be scaled up include: 1) Training and support of Community Health Teams in promoting facility based delivery and family planning, 2) integrated interpersonal communication training for facility staff, and 3) Support to the Department of Health (DOH) Child Health Week (Garatisadong Pampata)<br><br>• Private Sector – USAID supports integrated MCH/FP in the private sector through improved workplace services and information, support for private sector midwifery clinics, and work with local pharmaceutical companies to expand access to low cost FP commodities and other key MCH commodities such as ORS and zinc.<br><br>• Service Delivery – USAID supports the DOH's integrated Maternal, Neonatal, Child Health and Nutrition MNCHN strategy (of which FP is a strong component) which promotes "integrated services including pre-pregnancy services, antenatal care, care during delivery and postpartum and postnatal care". In addition, USAID supports integrated training of health providers in MNCHN skills, including AMSTL and ENC.<br><br>• Health System Strengthening - USAID/P has been a pioneer of integrated health system strengthening at the local government unit (LGU) level (provinces, cities and municipalities) to support a decentralized health system where LGUs are entirely responsible for delivery of primary health care services. USAID supports integrated planning and budgeting through five year Investment Plans for Health and Annual Operating Plans (AOPs).<br><br>***Areas of Future Integration***<br><br>• Health and Coastal Resource Management– Coastal communities are among the most densely populated and poorest in the Philippines. The USAID/P Offices of Health and Environment will continue to increase CPR and reduce unmet need for family planning in these key areas of marine biodiversity through integrated coastal resource management/family planning programming. |

| | |
|---|---|
| | • Health and Agriculture - Strengthen linkages between health programs and health/nutrition/agriculture activities including referral to feeding programs and linkages to bio-fortified products.<br><br>• Health and Water Supply and Sanitation - Proactively coordinate internally with the Office of Environment and Energy and externally with the Department of Health to assist local government units upgrade water supply systems, improve water quality and increase access to water in geographically isolated areas. Provide technical assistance to local government units and help introduce community based, low-tech innovative inputs that can improve water access and quality. |
| **Key Development Partners** | *USAID has formal coordination with the following partners:*<br>• Department of Health<br>• Local Government Units (provinces, cities, municipalities)<br>• PPPs with several private companies<br>• JICA: MCH collaboration with USAID in Leyte<br>*USAID coordinates with the following donors though the DOH-led donor forum. Below is a brief summary of donor development assistance portfolios.*<br>• ADB: equipment, service delivery, LGU systems strengthening<br>• AECID (Spain): equipment, civil works, capacity-building<br>• EU: TA, budget support, capacity building, drugs, equipment, insurance subsidies.<br>• KfW: service delivery strengthening in select areas<br>• UNFPA: strengthening/sustaining delivery of integrated RH services in select areas.<br>• WB: budget support for financing commodities and systems. Infrastructure, TA, and systems strengthening for safe motherhood in select areas. |

| **Health Systems Strategy** | | |
|---|---|---|
| | **Near term (2011-12):** | **Medium term (2013-16):** |
| **Principal Interventions** | **Service Delivery**<br>• Support integrated FP/MNCH/N services and information at the community and facility level.<br>• Provide assistance to LGUs to help them identify and target the poor for health services. | **Service Delivery**<br>• Continue targeted support to integration of services and focus on scale-up<br>• Link health services with the conditional cash transfer program of the Department of Social Welfare. |
| | **Human Resources**<br>• Capacity building of service providers at the decentralized health system level<br>• Capacity building of community and barangay health workers | **Human Resources**<br>• Help LGUs plan for staffing levels, coordinate training and plan supervision and outreach |
| | **Governance/Leadership**<br>• Advance the policy agenda and regulation as it relates to improving financial protection for the poor through Philhealth.<br>• Improve planning and budgeting at the LGU level | **Governance/Leadership**<br>• Technical assistance to help update the midwifery law and advocate for more comprehensive PhilHealth benefits coverage for MCH and FP services |

| | | |
|---|---|---|
| | **Financing**<br>• Technical assistance to LGUs on investment planning and annual operational budgeting, and how to advocate with elected officials for needed budgets<br>• Targeted TA to Philhealth to improve efficiency<br>• Improve DOH central granting to LGUs by improved guidelines and streamlining of administrative process | **Financing**<br>• Support for PhilHealth to move from a fee-for-service provider payment system to case-based payments<br>• Help reach underserved families through linkages with the conditional cash transfer program. |
| | **Medical Products, Vaccines and Technologies**<br>• Support LGUs to plan, forecast, procure and monitor commodity supplies<br>• Conduct a stock survey in the public and private sector to inform of availability of essential FP and MNCHN products<br>• Engage private sector pharmaceutical partners to introduce or increase production of FP and MNCHN related commodities | **Medical Products, Vaccines and Technologies**<br>• Support the introduction of uniject for FP commodities and oxytocin |
| | **Information Systems**<br>• Support the roll-out of the two contraceptive commodity tracking systems developed with USAID-assistance<br>• Continue to provide technical assistance to clean up data in the government Health Information System | **Information Systems**<br>• Provide technical assistance to ensure accurate and complete data provision in the routine system |
| | **Demand creation/communication**<br>• Scale up IEC/BCC campaigns at all levels with more emphasis on mass media and up-to-date IEC materials<br>• Scale up IPC/C training for service providers<br>• Support community health teams. | **Demand creation/Communication**<br>• Support community-based NGOs with small grants to extend outreach efforts<br>• Continue to build the capacity of the National Center for Health Promotion |

# USAID/Philippines BEST Program: FAMILY PLANNING

| | | | |
|---|---|---|---|
| **Goal** | **Increase Modern Contraceptive Prevalence** | | |
| **Goal Level Targets & Indicator** | **Indicators** | **Impact Targets-2016 and Baseline** | |
| | Modern Contraceptive Prevalence Rate | Baseline: 34% (2008)<br>Target: 42% | |
| | Unmet need for family planning | Baseline: 22% (2010)<br>Target: 14% | |
| **National Priorities** | **Priorities** | **Plans & Targets** | |
| | 1. To provide universal access to and use of integrated maternal, neonatal and child health and nutrition (MNCHN) services | DOH Administrative Order (AO) 29, issued September 2008. Subject: Implementation of an Integrated Maternal, Neonatal and Child Health and Nutrition (MNCHN) Strategy.<br><br>Target: To increase the modern contraceptive prevalence rate to 55%. | |
| | 2. To ensure that every pregnancy is wanted, planned and supported. | | |
| | 3. To ensure community-level service providers and private outpatient clinics shall provide MNCHN services including family planning | | |
| | 4. To engage in active identification and servicing of population segments with unmet needs for family planning | | |
| | 5. To provide assurance of a safety net of free family planning services and supplies for indigent potential users | | |
| **USAID Strategy** | | | |
| | **Near term (2011-12):** | **Medium term (2013-16):** | **2010 Baseline/ 2016 Outcome Targets** |
| | **Public Sector** | | |
| **Principal Interventions** | Scale up FP interpersonal counseling and communication (IPCC) training with all providers | Build the capacity of local health authorities to conduct IPCC training with limited and targeted TA. | Number of counseling visits for FP/RH as a result of USG assistance<br>Baseline: 615,524 (2010)<br>Target: 1,2M<br><br>Increase in USAID-assisted service delivery points providing FP counseling/ services |

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|---|---|---|---|
| | | | Baseline: 280 (2010)<br>Target: 840 |
| | Support in-service training for health providers on basic FP and up-to-date best practices | Train managers on supportive supervision techniques to reinforce on-the-job learning of providers and monitor quality | Number of people trained in FP/RH with USG funds<br>Baseline: 5445 (2010)<br>Target: 7,500 |
| | Increase access to long acting and permanent methods through training and TA. | Scale up the capacity of local health authorities to provide long acting and permanent methods | Unmet need for limiting methods<br>Baseline: 22% (2008)<br>Target: 7% |
| | Ensure women are screened for family planning needs when attending primary health care services and provided comprehensible information | Scale-up and consolidate integration of FP and primary health care services | Number of woman that discussed FP with health care provider<br>Baseline: 12% (2008)<br>Target: 50% |
| | Train all providers on contraceptive methods available immediately post-partum at the delivery site | Scale up integration of family planning and MCH services to target post-partum women | Percentage of RHUs that offer FP counseling for post-partum women<br>Baseline: 6% (2010)<br>Target: 75% |
| | Strengthen communications, outreach and services in the community, with special emphasis on injectables and LAPMs; FP myths; and positioning FP as a part of good health care<br><br>Introduce community based distribution of oral contraceptives and depo-provera injectable | Strengthen the capacity of LGUs to manage community outreach and community based distribution activities. | Decrease in percentage of women citing fear of side effects & health concerns as reason for non-use of contraception<br>Baseline: 35% (2008)<br>Target: 25% |
| | Assure contraceptive commodity security with increased budget contributions from the central DOH and LGUs for contraceptive procurement. | Continue budget advocacy and TA. | Funding leveraged<br>Baseline: $11.1 M (2010)<br>Target: $13.5 M |
| | Strengthen DOH and LGU ability to plan, forecast, budget and procure contraceptive commodities | Continue to strengthen DOH and LGU supply chain management ability | % LGUs implementing CSR plans<br>Baseline: 72 (2010)<br>Target: 630 |

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| | **Private Sector** | | |
| | Ensure a broad range of low cost FP products are available in the private sector by supporting local pharmaceutical companies to market products to networks not normally covered by mainstream distribution and to link them with LGUs. | Partner with private sector to make injectables more widely available where appropriate such as pharmacies | Annual sales of USG supported oral contraceptives (in cycles)<br>Baseline: 9.8 M (2010)<br>Target: 10.9 M<br>Annual sales (in vials) of injectables in the private sector<br>Baseline: 259,000 (2010)<br>Target: 367,000 |
| | Increase the number of private health providers offering long acting permanent method by training more providers, especially in strategic locations, to become referral points for LAPM services. | Scale up the number of private health providers offering long acting permanent methods | |
| | Increase availability of family planning services for working women and through private midwife clinics. | Scale up the availability of family planning services in workplaces and private midwife clinics. | |
| **Delivery Approaches** | **Near term (2011-12):** | **Medium term (2013-15):** | |
| | • Community-level service delivery through, RHUs and BHSs<br>• Information, education, and behavior change communication at all levels<br>• National and LGU level policy dialogue and advocacy<br>• Public Private Partnerships<br>• Commodity logistics management<br>• Technical assistance to national, regional, provincial, and municipal government and health officials, as well as the private sector.<br>• Integrated training for midwives on FP, maternal/newborn and child health | • Continuation of community-level delivery approach<br>• Clinical level service delivery through hospitals<br>• Continuation of appropriate health systems strengthening work | |

| USAID/ Philippines BEST Program: MATERNAL CHILD HEALTH | | |
|---|---|---|
| **Goal** | **Reduce Maternal and Child Mortality** | |
| **Goal Level Targets & Indicator** | **Indicators** | **Impact Targets – 2015 MDG and baseline** |
| | Maternal mortality ratio | Baseline: 162 (2006 FPS)<br>2015 Target: 52 (MDG) |
| | Under-five mortality rate | Baseline: 34 (2008 DHS)<br>2015 Target: 27 (MDG) |
| **National Priorities** | **Priorities** | **Plans & 2015 MDG Targets** |
| | 1. To Meet Millennium Development Goal (MDG) Targets | Under-five mortality rate<br>Baseline: 34 (2008 DHS)<br>2015 Target: 27 (MDG)<br><br>Newborn mortality rate<br>Baseline: 16 (2008 NDHS)<br>2015 Target: 8 (MDG)<br><br>Maternal mortality ratio<br>Baseline: 162 (2006 FPS)<br>2015 Target: 52 (MDG) |
| | 2. To rapidly reduce maternal and neonatal mortality through effective population-wide provision and use of integrated MNCHN services including pre-pregnancy services, antenatal care, care during delivery and postpartum and postnatal care. | 2-4. DOH Administrative Order (AO) 29, issued September 2008. Subject: Implementation of an Integrated Maternal, Neonatal and Child Health and Nutrition MNCHN Strategy. (MNCHN AO).<br>• To increase percentage of skilled birth attendance and facility based births from 40% to 80%.<br>• To increase percentage of pregnant women having at least four antenatal care visits from 70% to 80%. |
| | 3. To ensure a network of facilities that can provide a continuum of care from pre-pregnancy to post-partum supported by an adequate emergency communication and transportation system. | |
| | 4. To ensure every delivery is safe and to provide easy access to emergency obstetric and newborn care as well as family planning and reproductive health services. | |
| | 5. To strengthen the capacity of midwives through training and certification to adequately and appropriately respond to pregnancy-related complications and reduce maternal and newborn morbidity and mortality through administration of life-saving drugs. | 5. DOH Administrative Order 14. Issued May 2010. Subject: Administration of Life saving drugs and medicine by midwives to rapidly reduce maternal and neonatal morbidity and mortality. (AMSTL AO ) |

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| | 6. To ensure the provision of quality, evidence-based and time-bound interventions for newborns that are essential within the first 6 hours of life. | 6.Essential Newborn Care AO 2009 |

| Strategy | | | |
|---|---|---|---|
| | **Near term (2011-12):** | **Medium term (2013-16):** | **2010 Baseline/ 2016 Outcome Targets** |
| | **Maternal and Neonatal Health** | | |
| **Principal Interventions** | • Facilitate provincial- level planning and budgeting to **scale-up the implementation of the MNCHN Strategy**. | • Continue to support scale-up of the MNCHN Strategy | • Number of Maternity Care Package-accredited health facilities<br>Baseline: 259<br>Target: 750 |
| | • Support the DOH **ENC campaign** at all levels | • Expand the ENC protocol to include resuscitation. | |
| | • Improve the quality of **antenatal care** through group ANC sessions | • Continue targeted TA to support implementation of the group ANC sessions | |
| | **Improve Skilled Birth Attendants Skills** through the following:<br>• Build the capacity of midwives in the public and private sector in emergency obstetric and essential newborn care through revision of in-service training curricula, training, and supportive supervision.<br>• Scale up community health teams (CHTs) to encourage facility- based delivery (FBD).<br>• Assist public and private facilities to be accredited by the National Health Insurance Program. | • Expand the number of training sites for midwives at the LGU level<br>• Pilot innovative and low-cost ways of improving midwife performance<br>• Work with professional associations of ob/gyns and midwives to strengthen in-service training of midwives and other health workers in basic and emergency obstetric and neonatal care. | • Percentage of deliveries with skilled birth attendants (SBA) in USG assisted programs<br>Baseline: 62% (2008)<br>Target: 70%<br>• Number of people trained in maternal/newborn health through USG-supported programs<br>Baseline: 504 (2010)<br>Target: 6,500<br>• Percentage of facility-based deliveries<br>Baseline: 44% (2008)<br>Target: 60% |

<table>
<tr><td></td><td colspan="3">Child Health</td></tr>
<tr><td rowspan="3">Principal Interventions</td><td>• Improve care seeking behavior for under 5's through supporting CHTs, and the DOH Child Health Campaign</td><td>• Ensure poor children are enrolled in PhilHealth and are receiving adequate services.</td><td></td></tr>
<tr><td>• Expand use of ORS and zinc for diarrheal disease through: dissemination of the national protocol on micronutrient supplementation, support to WHTs, and</td><td>• Support to pharmaceutical companies to market and sell zinc to private sector outlets and public health facilities.</td><td>• Percentage of children under 5 years old with diarrhea treated with ORT in USG-assisted programs<br>Baseline: 59%<br>Target: 70%</td></tr>
<tr><td>• Partner with USAID/Ps water program to:<br>- Expand availability and use of safe drinking water, safe feces disposal and hygiene.</td><td>• Develop public private partnerships to subsidize access to safe water and sanitation products.</td><td></td></tr>
<tr><td rowspan="2">Delivery Approaches</td><td colspan="2">Near term (2011-12):</td><td>Medium term (2013-16):</td></tr>
<tr><td colspan="2">• Clinic- level service delivery through public and private health facilities and locations.<br>• Integrate FP into MCH services.<br>• Information, education, and behavior change communication at all levels<br>• National and LGU level policy dialogue, advocacy and technical assistance in planning, financing, and data management.<br>• Commodity logistics management<br>• Integrated training for midwives on FP, maternal/newborn and child health.</td><td>• Continuation of community and facility- based service delivery approach.<br><br>• Continuation of appropriate health systems strengthening work.</td></tr>
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| USAID/ Philippines BEST Program: NUTRITION | | | |
|---|---|---|---|
| **Goal** | **Reduce Under-Nutrition** | | |
| **Goal Level Targets & Indicator** | **Indicators** | **Impact Targets-2016 and Baseline** | |
| | Percent of infants exclusively breastfed in the first six months | Baseline: 23% (2008 DHS)<br>Target: 30% | |
| **National Priorities** | **Priorities** | **Plans & Targets** | |
| | 1. Reduce prevalence (%) of underweight children, 0-5 years old. | 1. Medium Term Philippine Plan of Action for Nutrition (MTPPAN) 2011-2016 (draft) National Nutrition Council, Department of Health.<br>Baseline: 20.6% (2008 NSS) National Nutrition Survey<br>2016 Target: 12.7% (MTPPAN) | |
| | 2. All infants are exclusively breastfed for 6 months | 2. Department of Health Administrative Order 2005-0014: National Policies on Infants and Young Child Feeding.<br>Baseline: 35.9% (2008 NSS)<br>2010 Target: 50% (NOH)<br>Note: This is the target in the National Objectives for Health 2005-2010. New NOHs are expected to be released soon and will contain targets for 2016. No target was established in the MTPPAN. | |
| | 3. Increase vitamin A supplementation coverage of children 6 mos-5 years old. | 3. (MTPPAN) 2011-2016 (draft)<br>Baseline: 75.9% 2008 Demographic Health Survey<br>2016 Target: 90% MTPPAN | |
| | 4. Reduce anemia among pregnant women. | 4. (MTPPAN) 2011-2016 (draft)<br>Baseline: 42.5% (2008 NNS)<br>2016 Target: severe <40%<br>moderate 21-<40%). MTPPAN | |
| **Strategy** | | | |
| **Principal Interventions** | **Near term (2011-12):** | **Medium term (2013-16):** | **2010 Baseline/ 2016 Outcome Targets** |
| | Strengthen communications, outreach and services in the community to promote exclusive and continued breastfeeding, appropriate complementary feeding, micronutrient supplementation, use of iron folate and ante-natal care | Continue to strengthen communications, outreach and services in the community to promote key nutrition interventions.<br><br>Advocate for and assist Department of Health to enforce the Milk code. | • Number of people trained in child health and nutrition through USG supported programs.<br>Baseline: 4,579<br>Target: 7,500 |

| | | | |
|---|---|---|---|
| | Support de-worming of children as part of the package of child health services | Continue targeted support for de-worming of children | |
| | Strengthen linkages between health programs and nutrition/agriculture activities including linkages to biofortified products. | Assure adequate budget for selected nutrition interventions at the LGU level | |

| | **Near term (2011-12):** | **Medium term (2013-16):** |
|---|---|---|
| **Delivery Approaches** | • National and LGU level policy dialogue and advocacy.<br>• Behavior change communication and interventions at all levels.<br>• Public Private Partnerships<br>• Community level service delivery.<br>• Commodity logistics management at all levels.<br>• Health information management at all levels.<br>• Clinic-level, using ANC as a platform, for iron folate, deworming and demonstrations of complementary food preparation. | • Continuation of community and facility based service delivery approach.<br>• Continuation of appropriate health systems strengthening work. |

**Annex – Consolidated Comments**

**Review of BEST Action Plan**
*Philippines*
*March 11, 2011*

*Summary of comments/questions:*

Family planning

- Focus on decreasing unmet need; it will achieve more. Most important point for USAID assistance is midwives and BHWs, not doctors and nurses. BHWs need to be identified better; many are not well informed and are the source of myths and misconceptions.
- Could IUD insertion and other skills be included in pre-service rather than just in-service training? Response: Where feasible, USAID/P will seek to incorporate in-service skills into pre-service training. In the near term we will work on upgrading the skills of already deployed midwives and providers while at the same time working with the Department of Health and professional associations to improve in-service training.
- USAID should consider the comparative advantage of private sector in FP. If it is in delivering spacing methods, could USAID dedicate its resources to building up long-acting methods in the public sector, especially for the poor.
- The Plan notes that two main reasons behind non-use of contraception are health concerns (21% of non-users in the 2008 DHS) and fear of side effects (14% of non-users). USAID should describe how it will address these two myths and, more broadly, seek to identify further barriers (cultural, religious, etc.) and address them, as appropriate.
- Scaling up demand for family planning through the women's/Community Health Teams, communications/IEC materials and various training activities (for field implementers and beneficiaries) provides an opportunity to strengthen the rights perspective and gender issues/concerns of beneficiaries and community-based workers/volunteers. Data gathered should be gender sensitive, and disaggregated for age and sex; process indicators should also address these concerns.
- Consider using national data, i.e., the National Household Targeting System of DSWD, when providing assistance to LGUs to identify and target the poor for UNFPA-donated commodities. Add an indicator – "Fear of consequences to go against family members opposed to FP."

Maternal health

- Reproductive Age Mortality Studies would provide better maternal mortality data than a mini-DHS but they are expensive. Could also get mortality data at community level from providers and CHWs.

- Legal constraints on services provided by midwives are a potential threat to rolling out essential obstetric and newborn services. Encourage GRP to address the issue in cooperation with the Philippine Obstetrics and Gynecology Society (POGS).
- POGS are key stakeholders; work with them on advocacy.

- Consider collaborating on MCH with JICA, which is building capacity of local water districts, in financial and technical management for sustainable water supply service in rural areas.
- Possible areas for UNFPA-USAID collaboration include logistics management, BEmONC, and life-saving skills training for skilled birth attendants, especially midwives (the latter in collaboration with UNICEF).

Child health

- USAID should assist DOH to scale up "First Embrace" newborn care campaign by rapidly incorporating new opportunities to develop resuscitation skills using practical learning such as the new Helping Babies Breathe program. Initial training of master trainers for further dissemination and institutionalization should begin immediately so that capacity can be brought to scale as ENC becomes more widely disseminated.
- Neonatal resuscitation training must only be pursued "once ENC has been widely disseminated," as ENC is the standard of care for approximately 90% of newborns. Efforts should not be diverted to programs of lesser impact and further dilute the effects of high impact interventions. WHO has community-based tools for sick child management, newborn care, and healthy growth and development that USAID can use.
- Introduction of pneumonia and rotavirus vaccines could have a great impact on the NNMR and therefore U5MR. What is the status of pneumococcal and roto vaccines?
- Introduce breastfeeding concepts during antenatal period and teach moms to support it. Pneumonia is a big cause of under-5 mortality. No vaccines available. DOH needs to commit funds to vaccines; USAID should advocate for this.
- More than 50% of childhood mortality is after the neonatal period. There is still low-hanging fruit – expand diarrhea prevention interventions, childhood vaccines, etc. Folate fortification will affect birth defects and thus neonatal mortality. Go Baby Friendly.
- Although funding is limited, support is important for three essential drugs: amoxicillin suspension for pneumonia, low osmolarity ORS, and zinc supplementation.
- IMCI should be at the core of training for child health and survival. The Garantisadong Program (Guaranteed Childhood) has been in place for 10 years or more; has there been a study of its impact on improved care-seeking and healthy practices?

Nutrition

- USDA has a One Health approach, under which health of animals, people and environment are linked. USAID could promote family planning at feed stores that farmers visit regularly; there could be interconnected messages about family size and farm issues.
- Nutrition underlies about one-third of childhood mortality. Sprinkles are a good start; the nutrition section needs to be fleshed out a bit more.
- Focus on first 1,000 days (pregnant mother and first 2 years of child's life) to make the most significant impact on stunting, wasting, and cognitive development. Develop indicators in FtF. This is also a fertile field for the commercial sector (e.g., fortified noodles); USAID can partner commercial sector with public sector and NGOs.

CCT

- Conditional Cash Transfers (CCT) is missing. CCT is a good platform to encourage the extremely poor to utilize healthcare services and good health behaviors, e.g., use of Sprinkles.
- The CCT program is the #1 priority of President Aquino regarding poverty. The DOH is not very involved in DSWD programs, except through the Social Cluster program. Need to bring DOH and DSWD together on reaching the poor with health programs.
- JICA will provide loan aid in cooperation with the WB and ADB to monitor effective uptake of essential health interventions and health impact of CCT recipients; this is an area of possible coordination with USAID.

Geographic focus

- LGUs have a paramount role in health especially to the poor in the public sector. USAID could inspire participation of LGUs by developing a demand-driven strategy in which LGUs are allowed to self-select to participate in the USAID program through a defined set of criteria. USAID can then leverage resources that LGUs bring to the table, including strong political commitment, thus increasing the potential rate of success.
- Are the provinces in which USAID proposes to work open to tubal ligation? Are they open to baby friendly hospitals?
  **Response: There are already some Baby Friendly Hospitals (BFHs) in the Philippines, which was one of the first places to have them. The Mission is also supporting work that encourages more patient-friendly practices at all facilities.**
- Are the CCT target areas the same as the areas the action plan is prioritizing? **Response: The majority of the ARMM is a CCT area so that is a clear area of overlap. We are also in the process of discussing the provinces with the DOH and plan to phase out of well performing provinces and take on additional CCT provinces. This will happen over the next several months as we negotiate the bilateral.**
- ARMM is a dispersed, conflict-prone area. Given the budget for the next five years, has the Mission weighed the tradeoffs of: a) cost-effectiveness; and b) feasibility of success given the security risks?
- Consider coordination with JICA in ARMM, where JICA is working on infrastructure and capacity building in the health sector in Mindanao.

PhilHealth

- Provide assistance to PhilHealth to increase the benefit ratio. USAID should consider shifting assistance to the public sector for IUDs and implants through PhilHealth.
- USAID should dentify incentives that can be built into the PhilHealth program that connect with CCT.
- USAID can help PhilHealth develop ideas that can expand its coverage. Examples: encourage progressive LGUs to join up with PhilHealth in terms of coverage; influence PhilHealth to implement a network accreditation of facilities instead of one facility at a time (e.g. FriendlyCare, if accredited as a network, can easily expand its number of facilities by franchising private clinics as part of a network providing integrated MNCH care, especially family planning, as the private clinics will have access to PhilHealth resources); or develop revenue generating measures such as the "sin tax" enacted on tobacco and alcohol with the revenues dedicated to a health pool.

- Current PhilHealth coverage is mostly for in-patient care. Consider working with PhilHealth on guidelines and implementation specifically incorporating preventive health care for infants, children and adolescents, e.g., essential newborn care and newborn care, immunization coverage in the OPD, tobacco and secondhand smoke exposure, injury prevention.

Health systems

- Identify the health systems barriers that don't allow health programs to be scaled up and focus on eliminating those health system barriers.
- On key health systems improvements required for near term (and longer-term scale-up) delivery approach, there must be some assessment to determine if they work or not.
- Support to LGUs on investment planning for health should include capacity enhancement in the conduct of gender analysis and rights mainstreaming. Strengthen capacity of LGUs to use gender-responsive budgeting.
- USAID and its partners need to focus on increasing the absorptive capacity of the DOH in crucial areas such as supply and procurement of commodities and health information systems. FP program may be an entry point to model and scale up in these areas.
- USAID may wish to consider the WHO MNCH HSS tool, a population-based survey that looks at service delivery channels and could be conducted every two years.

Behavior change programs

- Behavior change programs should also target community members, especially husbands. Programs with community outreach, mobilization and mass media campaigns are more effective approaches to changing behavior among men and boys than single-focus interventions. Need to train service providers on working with men and boys.
- USAID support for mass media activities may fill a resource gap as DOH historically does not have resources for highly visible and sustained mass media campaigns.

Equity

- Narrow the widening gap in health outcomes, fertility and rural/urban service coverage by expanding effective service points of primary health care and by strengthened financing through PhilHealth insurance. USAID also needs to work on capacity building and influencing vital policy commitment to equity at national and local levels.
- A "stronger focus on health outcomes" should include paying attention to equality and equity issues that impact on health outcomes as well.

Donor/partner coordination

- Only UNFPA, DoD, JICA, and the USAID/Offices of Environment and Energy are mentioned in the Plan. Much of the health program relates to behavioral changes; are there ways in which USAID can leverage its resources to achieve scale and impact?
- Add civil society partners such as Philippines Pediatric Society to strengthen community mobilization and advocacy. This will impact success and sustainability.

Monitoring/evaluation/research

- Collaboration in this area should strive for public-private partnerships and should be encouraged to engage local and international stakeholders in coalitions for improvement.

- Consider adding a focus on sentinel surveillance and community-based research that includes qualitative methods so that reasons why programs are or are not as successful in some areas can be understood and acted on.

Gender issues

- In ARMM, issues such as women's status and the continuing practice of early marriage should be recognized as causes for weak health indicators.
- Include implementation of the Magna Carta of Women (Section 20 – Women's Right to Health) in policy work at the national and LGU levels.

Water and sanitation

(UNFPA) Use KALAHI CIDSS in working on water and sanitation issues. Target areas that receive CCTs.